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RECOVERY-ORIENTED SERVICES – THE ROLE OF TRAINING IN TRANSFORMATION

Abstract

Recovery oriented practice / service provision – is how workers and services support people in their recovery journey. There are four identified practice domains: promoting citizenship, organizational commitment, supporting personally defined recovery, and working relationship. Professionals might be helpful if they are willing to be open, respectful and use their qualities as partners in healing, rather than “we – they” approach with paternalism and disempowerment. Also language matters in psychiatry, it is claimed to have the potential to contribute either to stigma and social exclusion or to people’ empowerment. One approach to supporting practice change is through well designed and aligned with the emerging conceptual dimensions of recovery training – users as well as providers needs some education how to benefit from the on-going reform.

Introduction

We need to create an optimistic, positive approach to all people who use mental health services. The vast majority have real prospects of recovery – if they are supported by appropriate services, driven by the right values and attitudes. The mental health system must support people in settings of their own choosing, enable access to community resources including housing, education, work, friendships – or whatever they think is critical to their own recovery.

The Journey to Recovery – the Government’s vision
for mental health care (DoH, 2001, p. 24)

Recovery

There is a broad heterogeneity in regards the outcome of serious mental illness (Carpenter & Kirkpatrick, 1988; Davidson & McGlashan, 1997). A number of people may recover from an acute episode of psychosis in ways that are similar to recovery from acute medical conditions; some others recover over a long period of time, after many years of disability. In this context recovery paradigm should not to be confused with cure but rather implies the provision of accommodations and supports that enable people with psychiatric disabilities to lead safe, dignified, and full lives in the community (Davidson et al., 2006).

Recovery has been understood as a vision, a philosophy, an attitude, a life orientation, an outcome and a set of outcomes (Silverstein & Bellack, 2008). The recovery process is a highly individualised, personalised journey and everyone has his or her own pace, often with the involvement of great suffering and unpleasant flash-backs, but also leading to transformation and personal growth. A person may experience more than one form of recovery at any given time, as well as move in and out of different forms of recovery over time (Davison et al., 2006), it may occur in distinct stages or phases which are characterised by qualitative differences in

behaviour (Tse et al., 2014). The metaphor of a spiral is suggested to illustrate its nature more clearly than the stages approach since often individuals revisit earlier stages before progressing on to later ones (Slade, 2009), moreover this concept is often disputable as labelling a person with “acquired stage” (Davidson et al., 2010). The most often described elements of recovery are: hope, autonomy and self-management, personal growth, capacity to change, tolerance and forgiveness, personal responsibility and productivity, peer support and community life, acceptance and self awareness (Deegan, 1998; Mead & Copeland, 2000). What is worth to note is Deegan assumption about paradox of recovery, i.e., that in accepting what users cannot do or be, they begin to discover who they can be and what they can do (p. 14). She therefore promotes individualised, recovery oriented rehabilitation programs with flexible structure, and also indicates that consumer-run self-help groups, self-help networks and advocacy groups as important resources for recovering persons. Mead and Copeland (2000) expect attitudinal changes in mental health professionals as well as training how to figure out what work for recovering people and what are the steps needed to take in their own behalf. Few years ago consultant psychiatrists from United Kingdom (SLAM/SWLSTG, 2010) published a document on key dimensions in recovery: hope, agency and opportunity. What makes it exceptional is the agency and opportunity component. Recovery means service users taking control over their own problems, the services they receive, and their lives. It is concerned with self-management, self-determination, choice and responsibility (p. 5). In this context recovery can be seen as a values-led approach which is focused on social and personally-valued outcomes. Essential to these values is partnership with many others within and beyond professional boundaries. The authors recommend to put a greater emphasis on recovery paradigm in the psychiatrists’ education and training at the undergraduate and postgraduate levels. This includes the development of the skills, knowledge and support to promote successful self-care, self-management and self-directed care.

Recovery oriented services

Personal recovery is a journey undertaken by people with lived experience of mental illness, recovery oriented practice / service provision – is how workers and services support people in their recovery process. Professionals might be helpful if they are willing to be open, respectful and use their qualities as partners in healing, rather than “we – they” approach with paternalism and disempowerment.

The transformation of systems towards person oriented practice, not illness focused foster its ability to realise full potential (Anthony, 2000). Appropriate self-revelation can help break down the professional barriers that create mistrust (Turner-Crowson & Wallcraft, 2002).

The Guidelines for Recovery Oriented Services were developed by the Quality Management Committee of the American Association of Community Psychiatrists (Sowers, 2005). The guidelines are composed into three quality domains of service administration, treatment and support. Author emphasises that their implementation requires a transformation of the way providers have been trained to think about their professionals roles – to learn how to be facilitative rather than directive, hope inspiring rather than pessimistic, autonomy enhancing rather than paternalistic (Sowers, 2005). In Le Boutillier et al. (2011) qualitative analysis of international recovery-oriented practice guidance the authors identified four practice domains:

promoting citizenship, organizational commitment, supporting personally defined recovery, and working relationship. To operate within a recovery framework, services need to balance the tension between addressing both the priorities of service users and the wider expectations of the community (p. 1475) – on a service provider level, recovery can present particular challenges in accommodating self-determination and choice along with the public protection expectations on the system.

To illustrate transformation challenges it is worth to cite some concerns about recovery in serious mental illness (Davidson et al., 2006, p. 640), derived by author from a series of presentations, discussions, and training sessions:

- *recovery-oriented care adds to the burden of mental health professionals who already are stretched thin by demands that exceed their resources. “You mean I not only have to care for and treat people, but now I have to do recovery too?”;*
- *recovery means that the person is cured. “What do you mean your clients are in recovery? Don’t you see how disabled they still are? Isn’t that a contradiction?”;*
- *recovery happens for very few people with serious mental illness. “You’re not talking about the people I see. They’re too disabled. Recovery is not possible for them.”;*
- *recovery only happens after, and as a result of, active treatment and the cultivation of insight. “My patients won’t even acknowledge that they’re sick. How can I talk to them about recovery when they have no insight about being ill?”;*
- *recovery can be implemented only through the introduction of new services. “Sure, we’ll be happy to do recovery, just give us the money it will take to start a (new) recovery program.”;*
- *recovery approaches devalue the role of professional intervention. “Why did I just spend ten years in training if someone else, with no training, is going to make all the decisions?”.*

Recovery oriented services – implications for practice

One approach to supporting practice change is through training. Studies in the USA (Peebles et al., 2009) and in Australia (Salgado et al., 2010) indicate that structured training on critical components of recovery can increase both knowledge and pro-recovery attitudes, as well as let trainees hear different perspectives on client care. Some trainings are conducted mostly by researchers and clinicians (Crowe et al., 2006), others are run by consumers (Young et al., 2005). A randomized controlled trial (Cook et al., 1995) found that staff educated by a consumer trainer had more positive recovery scores than did those by a non-consumer trainer.

In Tsai (et al., 2010) study authors examined the types of recovery-oriented training at two state hospitals and the impact of the training on staff recovery attitudes. Recovery-oriented training was grouped into one of two categories: specific/practical skills training or general/inspirational training. General/inspirational training included Roadmap to Seclusion and Restraint Free Mental Health Settings, “‘comfort room’ workgroups, ‘bridge building’”, and Respect seminars (p. 337). Specific/practical skills training included trainings on Illness

Management and Recovery, Integrated Dual Disorders Treatment, Wellness Recovery and Action Planning, the Matrix model, and motivational interviewing (p. 338). Staff who received specific/practical training had a greater increase in agency recovery attitudes than staff who received only general/inspirational training or no training.

Gilburt et al. (2013) evaluated the four full-day workshops and an in-team half-day session on supporting recovery. The trainers represented professional expertise and lived experience. The intervention was offered to 383 providers in 22 multidisciplinary community and rehabilitation teams providing mental health services across two bordering regions. Day 1 was introductory in regards recovery and the different elements that constitute a recovery approach. During the Days 2 and 3 trainers used training package *Psychosis revisited – a psychosocial approach to recovery* (Basset et al., 2007). Day 4 covered different topics: assessment and care planning from service users' perspectives; social inclusion/vocational activities from a social work perspective; carer perspectives on recovery; spirituality and reflection on personal values and beliefs, strengths based approaches and the role of hope. A half-day meeting with participating teams was held, to support team members to reflect on the active part of the training, and to discuss practical use of the training content. 89% staff attended at least one training session, and 48% attended all four workshops. The training program had a positive impact, with change in the content of patient's care plans and the attributed responsibility for the actions detailed. What is surprising in the authors' results is that there was much confusion about what "recovery" meant and subsequently what is participants' perceptions of recovery-orientated practice. Secondly recovery was perceived as something that professionals do, many trainees believed they "already did recovery".

It means that users as well as providers need some education and training how to benefit from the on-going reform: empowerment (individual and social) paradigm, partnership and consistent with recovery words and language.

Recovery oriented language

Words are important. The language we use and the stories we tell have great significance to all involved. They carry a sense of hope and possibility or can be associated with a sense of pessimism and low expectations, both of which can influence personal outcomes.

Devon Partnership Trust and Torbay Care Trust (2008, p. 2)

Language matters in psychiatry (Walker, 2006). It is claimed to have the potential to contribute either to stigma and social exclusion or to empowerment of people using mental health services (Dickens & Picchioni, 2011). Professionals should accept that people often talked about the onset of their first breakdown using everyday language such as "stress", "depression", "trauma" rather than talking about the onset of a mental illness. Most people who may be described as in recovery from mental illness neither think nor talk about the term "recovery" at all. They talk about getting a job, making friends, having faith, living on their own, and generally getting their lives back.

It is also worth to note that a variety of terms are used by health and social care professionals and by service user groups to refer to people with mental disorders. The terms used include "patients", "clients", "service users", "people affected by

mental illness” (Simons et al., 2010). Health service user groups advocate the terms: “ex-patient”, “psychiatric inmate”, “survivor” (Chamberlin, 1990) or “user” (Neuberger & Tallis, 1999). A systematic review of the empirical studies about the terms used to refer to people who use mental health services revealed that the terms “patient” or “client” were indicated most often by respondents as preferable ones, with “patient” being the most popular in the UK and “client” being regarded as the best option in the US (Dickens & Picchioni, 2011). In Polish study (Anczewska et al., 2011) also the term “patient” was the most preferred one, as well as by the recipients (76,2%), as the providers (87,7%) of the services.

Conclusions

The aim of the effective services provision, set in a positive culture of healing, is to assist users in the process of recovery and social inclusion. Services transformation into recovery-oriented ones forms specific challenges, namely in accommodating self-determination and choice along with the public protection expectations on the system. One approach to supporting practice change is through well designed and aligned with the emerging conceptual dimensions of recovery training – users as well as providers needs some education how to benefit from the on-going reform.

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